

**REPRODUCTIVE HEALTH NEEDS IN COMPLEX HUMANITARIAN EMERGENCIES:
AN ANALYSIS OF MEDECINS SANS FRONTIERES' PROGRAMS IN THE
DEMOCRATIC REPUBLIC OF THE CONGO**

by

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ABSTRACT

Objectives: 1) To examine reproductive health needs in the Democratic Republic of the Congo's (DRC) most severe conflict zones; 2) to examine the role Medecins Sans Frontieres (MSF) plays in addressing these needs in the region.

Methods: Data were collected through conducting literature searches, reading books written on MSF, and thoroughly navigating the MSF website in order to find relevant pod-casts, articles, press releases, and publications. Findings were analyzed using principles outlined in the "Inter-Agency Field Manual on Reproductive Health in Refugee Situations" published by the Inter-agency Working Group on Reproductive Health in Crises.

Results: Of the six analysis criteria against which it was judged, MSF demonstrated commitment to all, though with varying degree. Its work as an organization, as well as projects specific to the DRC, demonstrates particularly high quality of care and attention to human rights.

Conclusions: Though organizations such as MSF are crucial to providing essential maternal health services during Complex Humanitarian Emergencies (CHE), they cannot always overcome political instability and violence, and often fail to build long lasting health systems. Their work should be complemented with additional awareness campaigns and support from local NGOs.

INTRODUCTION

As Complex Humanitarian Emergencies (CHE) increase, so do the reproductive health (RH) needs of women affected by these conflicts. In addition to losing access to a number of essential services due to violence and the destruction of health facilities, women often become victims of sexual violence and the complications associated with these acts. The goal of the analysis that follows is to provide an understanding of how medical humanitarian organizations address these issues. The work of one specific organization, MSF, and its work in the midst of a CHE in one specific country, the Democratic Republic of the Congo will serve as the focus of the analysis in the hopes that lessons learned from these specific examples can later be applied to the way in RH services are provided in future CHE.

PROBLEM STATEMENT

Providing a basic definition of what constitutes a complex humanitarian emergencies, the scope of their influence around the globe, and the manner in which reproductive health suffers as a result helps to frame the current conflict in the Democratic Republic of the Congo. These definitions, along with a brief overview of the reproductive health indicators reported within the DRC, will begin to shed light on the issues that organizations such as MSF must deal with when they decide to intervene in a conflict situation.

Complex Humanitarian Emergencies – a definition

Salama et al. (1) defines complex emergencies as “situations in which mortality among the civilian population substantially increases above the population baseline, either as a result of the direct effects of war or indirectly through increased prevalence of malnutrition and/or transmission of communicable disease, particularly if the latter result from deliberate political military policies and strategies”. With baseline crude mortality rates in sub-Saharan Africa hovering around 0.5 deaths/ 10,000 persons per day, when the crude mortality rate (CMR) rises to or above 1 death/10,000 persons per day a conflict is classified as a public health emergency. (2) A multidimensional phenomenon involving numerous players, in CHE violence often causes fewer deaths than do disease and a lack of access to health care, and although soldiers may be the main perpetrators of violence, they are not the conflict’s main victims.

A myriad of political and economic factors, mainly the end of the Cold War and the proliferation of easily accessible and inexpensive military technologies, has contributed to a steady rise in the frequency and scale of complex emergencies over the past twenty years. Whereas an average of 5 complex emergencies per year occurred between 1975-1985, this number had risen to 40 by 1998. (2) The ethnic cleansing in Rwanda, the Serbian-Bosnian war in the early 1990’s, and today’s ongoing conflict in Afghanistan all serve as examples of recent complex humanitarian emergencies.

The Democratic Republic of the Congo

Cited as the “complex emergency of all complex emergencies”, the “deadliest documented conflict in African history”, or “the African world war”, the violence that continues to this day in the DRC is estimated to have cost the country 3.1 million of its 70 million citizens in the past 3 years. (2, 3) Plagued by corruption, war, and instability since gaining its independence from Belgium in 1960, the most devastating period of fighting began in 1998 when tensions from neighboring Rwanda spilled over into the country. Over the next four years, both Rwandan and Ugandan militia groups maintained strong presences in the Eastern and Western DRC respectively, with no peace agreement reached until 2002. (3)

Despite the official end of the war, rebel groups maintain control over certain parts of the country, and clashes between these groups and government troops continue. The Eastern provinces, which have seen some of the worst fighting conditions, estimate that 90% of inhabitants have become internally displaced due to the violence. 75% of them live in rebel controlled areas. (4) In these areas, CMR remains high. A 2007 survey conducted by the International Refugee Committee IRC reported a rate of 2.9 deaths/1,000 persons per month (which translates to 0.9 deaths/10,000 persons per day), with certain provinces reporting rates as high as 7.1 deaths/1,000 persons per month (2.4 deaths/10,000 persons per day). (5) These indicators, along with several others to be discussed in sections to follow, many of which have not changed since 2004, place the DRC firmly in a public health emergency.



Map of provinces in the DRC (6)

Reproductive Health in Complex Emergencies

If reproductive health is described as “a state of complete physical, mental, and social well being in all matters relating to the reproductive system and its functions and processes. It implies that people are having a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so,” (7) then it should include, at the very least, access to safe delivery, contraception, family planning methods, and abortion services. Demand for these services, hard to guarantee even in developed countries, increases greatly during complex emergencies. Areas affected by complex emergencies often

report elevated rates of HIV/STDs, unsafe abortions, lack of access to contraceptives, a rise in the maternal mortality rate due to pregnancy complications, and vulnerability to rape and other forms of sexual violence by armed groups. At the same time, the physical destruction of roads and health facilities, the loss of family and support groups, increased poverty and loss of livelihood, and a prioritization of other health issues leave women with few options or places to seek care. (7)

Reproductive Health in the DRC

Wreaked by constant conflict, insecurity, unstable conditions, and a poor economy, in the DRC, reproductive health ranks low on the government's list of priorities. Estimates published by the Kaiser Family Foundation put health expenditure per capita in the DRC at \$23, compared with \$112 in Uganda, \$147 in Sudan, and \$843 in South Africa. (8) The most generous of estimates claim that the DRC allocates 3.5% of its national budget to health. (5) Other sources report the number closer to 1% or even nonexistent in certain areas controlled by rebel forces. Health care providers are not paid, poorly trained, and few and far between. In 1998, the DRC had only 2,056 doctors serving a population of 50 million. Broken down, there country has 1 practicing physician and 5 midwives for every 10,000. (8) According to the Ministry of Health, less than 30% of health zones are functional and those facilities that do exist often run on a cost-recovery system— providers who go unpaid by the government charge high fees for their services, making care inaccessible to the majority of the population.(4)

Reproductive health care indicators are predictably low. Huge disparities exist between national averages and the conflict prone areas in the East. The maternal mortality ratio in the country, estimated between 549-1100 maternal deaths per 100,000

live births, already one of the highest in the world, is thought to be as high as 3,000 in the Eastern provinces. (4, 8) Contraceptive prevalence, at 6.7% nationwide for women reporting using modern form of contraceptive, dips to 3.3% in the East. (9) As a direct result of the armed conflict, rates of rape and other forms of gender -based violence have increased dramatically. A lack of data collection combined with the failure of women to disclose incidents of rape due to stigma means that the true magnitude of rape remains unknown, but a DRC Demographic Health Survey conducted in 2007 reported that 400,000 women aged 15-49 had experienced rape during the year. Once again, the highest rates occurred in the Eastern provinces of North Kivu, South Kivu, and Maniema. (9)

Troubling in their own right, high levels of sexual violence and limited access to obstetric services have both contributed to an increasing number of women suffering from fistula (both traumatic and obstetric). The Ministry of Public Health in the DRC estimates 12,000 recorded cases of fistula every year, with a quarter of these cases coming from only 3% of the country's population, women in the Eastern province of Maniema . (10,11)

Medecins Sans Frontieres

Started by a group of French physicians in 1971, MSF is one of the oldest and largest independent medical humanitarian organizations currently operating on a global scale. Every year it works with a budget of approximately \$400 million, which it uses to send more than 3,000 volunteers to around 80 different countries. (12, 13)

Throughout the past forty years, its 19 international offices have set up programs to help Cambodian refugees fleeing the Khmer Rouge, treat malnutrition in Ethiopia, and provide medical care to victims of the civil war in Afghanistan. Yet, in terms of programs, staff, and budget, the MSF presence in the DRC is by far the organization's biggest commitment to date.

In 2010, MSF teams provided more than one million medical consultations, more than 10,000 surgeries, and delivered 19,200 babies in the country. Projects focus on acute emergency care, cholera outbreaks, fistula repair, vaccinations, and malnutrition. (13)

ANALYSIS CRITERIA

Prior to the 1990's, traditional responses to complex emergencies focused primarily on combating malnutrition and infectious disease, with attention directed mainly towards water, shelter, and sanitation. The launch of the WHO's Safe Motherhood Initiative, coupled with the acknowledgement of the reproductive health needs of refugees at the 1994 International Conference on Population and Development in Cairo, led to the formation of an Interagency Working Group on Reproductive Health in Refugee Situations and the publication of the "Inter-Agency Field Manual on Reproductive Health in Refugee Situations". (14, 15) Chapter One of this manual, revised and republished in 1999, outlines the fundamental principles of reproductive health (RH) programming in humanitarian settings. Of these principles, the following six will be used to evaluate the way in which MSF meets

reproductive health care needs in the Eastern provinces of the DRC:1) quality of care, 2) communication, 3) community participation, 4) technical and managerial capacity-building, 5) human rights, and 6) advocacy. (16)

METHODS AND DATA COLLECTION

The data presented come from two main sources: a literature search and an extensive review of the publications available through MSF's webpage.

The literature search, conducted through Google Scholar and PubMed used a combination of the following terms: "maternal health", "women's health", "reproductive health", "complex emergencies", "violent conflict", "conflict area/zones", "emergency medical services", "humanitarian organizations", and "Democratic Republic of the Congo". No limitations were placed on publication dates, although the majority of search results had been published after 1998.

The majority of information on MSF and its work in the DRC came from various publications, podcasts, blogs, and press releases found on the organization's website (doctorswithoutborders.com). Two books written specifically on MSF, "Hope in Hell" by Dan Borolotti and "Touched by Fire" by Elliot Leyton proved particularly useful while researching the early years of the organization.

FINDINGS

The following section will highlight the various reproductive health activities conducted by MSF teams in the DRC. Though work in a handful of towns and provinces is examined, the main area of focus is Masisi, a town in the province of North Kivu.

Emergency Obstetric Care

In Masisi, the majority of Congolese women deliver their babies at home or at local health clinics ill-equipped to deal with any obstetric emergencies. Should complications arise, the clinic refers its patients to the MSF-UK team, which operates the only free maternity ward in the region. When MSF gets a call from a clinic, it will immediately send an ambulance and a clinician to meet the woman in labor. Two vehicles are taken to make the trip, in the case that one gets stuck on the notoriously bad roads and must be pulled out by the other. While the MSF team attempts to provide ambulance services to as many women as possible, it is not unheard of for women in labor to walk hours (if not days) in order to reach the maternity ward.

The maternity ward itself consists of one delivery room equipped with three delivery beds. Hospital staff include two Congolese physicians who work with the MSF midwife, 21 nurses and midwives, 10 ambulance drivers, and 6-8 cleaners. In 2010 alone, 3,451 babies were delivered at the facility. 665 were delivered by caesareans performed on women who in all likelihood would have died without the procedure. 6 ended with the death of the mother. The hospital also delivered care to

175 premature babies, putting them on ventilators and feeding tubes until they gained the strength they needed to return home.

A “Village des Mamans” (or “Village of Mothers”) adjacent to the hospital hosts up to 70 women experiencing high-risk pregnancies. During their stay, the women receive a number of health education classes that cover topics specific to maternal health such as nutrition, breastfeeding, and birth spacing. Their proximity to the hospital allows hospital staff to attend to them the minute they go into labor or begin to experience any pregnancy-related complications. Of these women, one in five requires emergency surgery.

When security allows, the staff runs twice-weekly mobile clinics to the refugee camp in Bukombo. (17)

Sexual Violence

Though often used as a tool of war in complex emergencies, the number of rapes perpetrated by armed groups in the DRC is exceptionally high and disturbing. In Eastern DRC, MSF teams treated 6,700 victims of sexual violence in 2008 alone. (18)

MSF adopts a multi-dimensional approach to treating victims of sexual violence, which includes psychosocial support, surgery when appropriate, and administration of the appropriate prophylaxis. Patients receive HIV prophylaxis if they arrive within 72 hours of the rape. Hepatitis B vaccine, tetanus vaccine, and various antibiotics to prevent the development of Chlamydia, syphilis, and

gonorrhea are also administered. If medical care is sought within 120 hours of a rape, the practitioner will also provide the patient with an emergency contraceptive pill to prevent unwanted pregnancy. (19)

In the Masisi district, where MSF has been providing emergency medical care to a population of 337,000 residents and displaced people since 2007, a special room in the MSF clinic has been adapted to receive rape victims and ensure their privacy. Equipped with 175 beds, teams in Masisi treated an average of 45 new victims of sexual violence every month in 2008. However, only 20% of women arrived within 72 hours of the rape, and 75% arrived after five days, at which point preventive HIV treatment and emergency contraception no longer work. (19, 10) Fighting, geographic isolation, and the fear of disclosure of the rape prevent women from seeking care at all, while a lack of access to and awareness of services impede women from coming earlier. (19)

To improve awareness and use of MSF services, “mamans conseillieres” take on the responsibility of spreading the message regarding sexual violence. These women, elected by their villages, serve as a resource for victims of sexual violence. They work within their own village but also travel around explaining the importance of medical care after an incidence of rape and try to persuade victims to seek care at the MSF hospital. Working in parallel with the mamans conseillieres, community health education teams organize trainings for primary and secondary school teachers on the medical dangers of sexual violence and the health care available at the hospital in Masisi. Awareness raising activities held at the hospital,

and radio messages targeting victims of sexual violence, increase the diffusion of the message. These outreach activities are often limited by the lack of security. (19)

On January 1, 2010, an MSF team responded to reports of a mass rape occurring Fizi, a small town in South Kivu. The victims, 33 girls and women, had been brutally raped by a group of armed, uniformed men. Attacks began at 8 PM that night and did not cease until 4 AM the following morning. The MSF team managed to reach Fizi by January 3rd and treated 14 women before returning the following day to treat 19 more. All women were reached in time to receive HIV prophylaxis and other appropriate medications, and two of the women were transferred to the hospital in Baraka due to the severity of their wounds. The MSF team was unable to return and deliver psychosocial treatment due to security issues. (20)

Obstetric and Traumatic Fistula

To address the need for fistula treatment in the Eastern provinces, MSF mounts “fistula camps” for two months at a time near already existing hospitals. In preparation, additional employees are hired, 40-80 additional beds made up, and the surrounding populations are informed that the camp will arrive soon so that women have enough time to come in for consultations. A surgeon, called in specifically to perform fistula repairs, works on site operating on several women a day. (21) Between 85-88% of fistula operations performed at MSF camps are successful, but in 8% of surgeries the fistula does not close properly and the woman is asked to return at a later date. Sometimes, the damage in the vagina is too

extensive and the patient is inoperable. In an effort to achieve as many successful operations as possible, women scheduled for surgery check in to the camp two weeks ahead of time. All women are kept extremely well hydrated, and those who show signs of malnutrition are provided with nutritional supplements. Following the operation, women stay at a nearby hospital for an average of five weeks where they are closely monitored to ensure the fistula is healing correctly and that continence is maintained. (22) In Masisi hospital in North Kivu and in surgical “camps” in Katanga, more than 130 of these operations were carried out in 2010. (18)

HIV/ STI

Women living in the DRC face a high risk of contracting STIs due to three inter-related factors: low contraceptive use (as low as 3% in rural areas), the prevalence of rape described above, and the fact that the DRC’s armed forces have one of the highest STI rates in the world. (23) Socioeconomic instability also has pushed many to sell sexual favors in exchange for food, shelter, or money.

MSF-Belgium has helped the Ministry of Health (MOH) develop a national protocol for the syndromic treatment of STIs and helps to support the integration of STI treatment into primary health care in 24 facilities located in Kinshasa, Equateur, and Katanga. Commercial sex workers (CSWs) are the main targets of these efforts, and these individuals may now receive STI treatment, as well as family planning services and emergency contraception, at subsidized costs for both themselves and their partners. Locally trained peer educators meet with CSWs on a regular basis to

encourage them to visit the clinic and undergo HIV testing. Clients who test positive are then referred to local NGOs who specialize in providing psychosocial support to HIV positive individuals. It is estimated that the clinic in Kinshasa treats approximately 50 clients per day. (4)

INTERPRETATIONS OF FINDINGS

Quality of Care

In order for an organization to demonstrate quality of care, the services they provide must address the reproductive health needs of all persons without discrimination. These services must also be accessible, inclusive, effective, and comprehensive in nature. MSF addresses this first element of anti-discrimination through its charter (24), in which it states “MSF provides assistance to populations in distress...irrespective of race, religion, creed or political convictions”. Providing services free of charge and transportation to and from clinics is its way of ensuring accessibility and inclusivity of services.

Basic maternal and newborn health services such as antenatal care, caesarean sections, STI testing, and neonatal care are provided at the various health clinics and hospitals MSF operates throughout the region. Specialized care for reproductive health needs that have arisen over time as result of the conflict has also been incorporated into standards of care, mainly by adding emphasis to care for victims of sexual violence and those suffering from fistula , and by providing family planning and mental health services when appropriate.

Yet despite a strong presence and significant commitment to the region, quality care does not always translate to consistent care. There exists no permanent obstetric fistula camp in the region. Patients unable to reach fistula camps during the two months in which they operate miss a valuable opportunity for the surgery. And though the teams do as much as possible to overcome the poor infrastructure predominant throughout the DRC, there are times when mobile clinics simply cannot reach certain populations (whether due to poor roads or outbreaks of violence).

Communication and Community Participation

The principles of communication and community participation both emphasize the importance of involving community members in actions and decisions regarding their own health care. Communication, as described in the field guide, (16) involves “transmitting information through appropriate channels in order that people get the information they need, when they need it, in the way that makes sense to them so that they can make practical decisions”. Communication on both an individual level and a community level is important, and MSF demonstrates a commitment to this principle through the way in which it uses community members to disseminate information about gender based violence, availability of services, and maternal health. Of note, the majority of the time communication strategies are used to promote awareness of specific MSF activities and not necessarily general reproductive health messages.

The extent to which community participation plays a role in MSF's work is a bit more difficult to evaluate. To a certain degree, community participation is crucial to the work that MSF carries out. Successful program implementation relies on close collaboration with health ministries, the training of local staff, and understanding population needs. Yet, inherent to MSF's core values lies a mentality of disengagement and short-term aid. The organization manages to maintain its own logistics chain in a manner that makes it entirely independent and self-sustainable. Its main goal is to alleviate pain in the present, and it feels no responsibility towards rebuilding a failed system. This type of disengagement allows for the consistent provision of quality services, but they come at the expense of community involvement and program longevity. Yes, locals are trained and hospitals are built, but once MSF leaves the country, who will the hospitals turn to for drug stocks, transportation vehicles, and modern medical equipment?

In the instances where dependency on an MSF system evolves, usually after several years of presence in a region, disengagement can prove extremely difficult, time consuming, and at times harmful. The example to turn to in the DRC is that of the recent handover of its Bon Marche hospital operations in Bunya to the Ministry of Health hospital. Over the seven years that the hospital had operated in the region it had become the region's main health care center. During the three -year transfer period, the MSF team had to expand the physical capacity of the MOH hospital, re-train all hospital staff, and work with local authorities to recruit enough staff to fulfill demand. The financial resources MSF had brought with it over the years

would no longer be of help, and certain programs, such as neonatal services, were cancelled. (25)

Advocacy and Human Rights

Human rights make up the core of MSF's charter and, as with quality of care, commitment to this principle is evident throughout the various programs MSF provides to its patients in the DRC. In addition to ensuring it provides impartial assistance to those in need, MSF also issues medical-legal certificates to victims of rape who come to the clinic for help. These certificates, though relatively useless at the moment, can one day be used in court should the victims wish to press charges against their perpetrators.

A key component of advocacy for these human rights is to "target laws, policies, practices, and social norms that affect whether individuals or groups share access to RH information and services". (16) Throughout its history of fieldwork, MSF has made "bearing witness and speaking out against the atrocities it witnesses in the field" central to its mission as a humanitarian organization. (12) MSF-US consistently advocates with the UN and the US government on humanitarian concerns and, in 2007, denounced the targeting of civilians in conflict, particularly in the DRC. It consistently publishes special reports, briefing documents, and slideshows on various public health topics. Reports on the DRC have brought attention to the cholera epidemic currently spreading along the Congo River, an Ebola outbreak in 2008, and the plight of the thousands displaced civilians. However, in the 20 plus years that MSF has operated in the DRC, only one special

report related to reproductive health has been published. The website doctorswithoutborders.com does little to draw attention to maternal health issues, and it is extremely difficult to find data on reproductive health programs.

Technical and Managerial Capacity-building

The Inter-Agency Field Manual states that in order for organizations to demonstrate technical and managerial capacity-building they “must have the management systems in place to: hire, train, place, supervise and support service providers, maintain facilities and equipment, ensure supplies, designs, monitor and evaluate services, engage with stakeholders, raise and manage funds”. (16) The manner in which MSF has managed to address each of these criteria has been addressed at some point in this section in relation to other principles and in an effort to avoid redundancy, will not be repeated here.

Coordination and Accountability

Mainly due to a lack of appropriate data, the principles of coordination and accountability were not reviewed for this particular analysis.

IMPLICATIONS FOR MATERNAL AND CHILD HEALTH

The activities and subsequent evaluation outlined above shed light on the fact that, despite the numerous resources MSF devotes to reproductive health services in the DRC, there exists room for improvement in the way in which the

organization addresses the health care needs of women during CHE. Though MSF doesn't blatantly ignore any of the principles, it also does not whole-heartedly embrace any of them. For those principles in which MSF fails to fully meet all standards, improvements must either be made within the organization or within the international community to address the gaps. The policy changes suggested below highlight three different types of recommendations: areas in which MSF should continue to provide services, areas that need improvement but may be outside the scope of MSF's work, and areas in which MSF can significantly contribute more than it already does. All three complement each other and will need to be taken into account in future CHE.

Continuing to Provide Quality Care

High quality of care, perhaps the most important element of interventions during the acute phase of complex emergencies, forms the backbone of program activities and cannot be compromised. Throughout its time in the DRC, MSF programs have done an excellent job of providing quality care to women of reproductive age. They have addressed the two largest barriers to access to care, cost and geography, by providing free services and arranging transportation for their patients. They have identified reproductive health needs unique to this population and addressed them with comprehensive sets of services. In many of the Eastern provinces, MSF -run hospitals and clinics represent the only accessible form of health care. They are the most reliable providers of emergency reproductive

health services and should continue to provide these services in future complex humanitarian emergencies.

Improving Population Health Indicators

Yet despite this commitment to providing quality care, maternal health indicators in the Eastern provinces of the Congo remain low. MSF cannot reach all those who need services and so their efforts do not translate to visible improvements in reproductive health indicators at the population level.

If real, long-lasting improvements to reproductive health are to take hold in the DRC, efforts must focus on preventive health care at the community level. For example, the unmet need for family planning services in the DRC is huge, especially among adolescents. The total fertility rate, at 7.1, has been increasing since 1950 despite a recent study conducted in North Kivu that found that 58% of women surveyed were interested in family planning but only 3% used modern methods of contraception. (26) Because many complications during pregnancy are associated with poor birth spacing and/or the small stature of young girls, it would stand to reason that, by meeting family planning needs, rates of maternal mortality will fall along with rates of unwanted pregnancies. Though MSF provides family planning services to those women who present at their clinics, they do not actively try to disseminate messages on family planning throughout the communities in which they work. Women are unlikely to present at an MSF clinic unless they are sick or experiencing complications during labor (and even then not all women choose to seek care), which means that the majority of the population has no exposure to MSF

family planning services. The international community should recognize MSF's limited involvement with community based health education and act accordingly. This could involve making sure other NGO's take on community health roles, helping the Ministry of Health provide reproductive health services, or pushing MSF itself to improve these parts of service delivery.

Increasing advocacy efforts

The failure to incorporate community outreach as a part of reproductive health services does not mean that MSF has no role in creating observable change. MSF might be one of the most well known humanitarian organizations in the world. Because it relies almost exclusively on private donations to fund its programs, its publicity and fundraising techniques, and its ability to draw attention to particular issues, are particularly strong. On its website, through various publications, and at exhibits in the United States, it regularly highlights topics such as malnutrition and access to essential medicines, which are central to its work in the field. Though MSF also discusses reproductive health needs through these media, it does so rarely. Not only should the organization increase the frequency with which it produces reports on reproductive health needs; it should also increase their visibility on the MSF website and even consider devoting a campaign or exhibit to the issue.

Ramping up advocacy efforts will ideally lead to a tri-fold effect. It will allow MSF to devote more resources to its own reproductive health programs, it will increase the number of organizations and individuals who choose to focus their efforts on reproductive health issues in areas of conflict, and eventually it will

contribute to changes at the policy level. Of these desired effects, the third, whether through increased pressure on ministries of health or re-allocation of aid agency funding, has the largest potential to improve reproductive health care in conflict situations.

WEAKNESSES

As with all analyses, certain weaknesses do exist in the methods of data collection.

When speaking of reproductive health, the analysis focuses for the most part on women of reproductive age. That being said, reproductive health program should target men, adolescents, children, and even the elderly as they all play a role in reproductive health choices and behaviors.

The majority of information regarding MSF and its programs in the DRC comes directly from the organization's various websites, and predominantly from those managed by MSF-USA and MSF-UK. Though there is no reason to believe that any of the information is inaccurate, it is likely that certain criticisms and unfavorable data, which would have been useful to this evaluation, may not be featured on the website.

A lack of access to program evaluations and clinic records means that this paper was not driven by scientific data but rather by narratives and field reports.

Due to a dearth of present day data on programs operating in the DRC, the information collected focuses mainly on the years 1998-2008. It is unlikely that

indicators have drastically changed since 2008. If anything, they may have gotten worse.

CONCLUSION

As the situation in the DRC illustrates, reproductive health indicators suffer tremendously under complex humanitarian emergencies. Not only do women become more vulnerable to certain health complications; they also lose access to basic health care services. During these CHEs, there exists a very real need for organizations such as MSF to intervene and provide RH services. Through mobile clinics, outreach programs, and minimal hospital fees, MSF makes it possible for women in the DRC to access services such as obstetric surgeries, fistula repair, and STI treatments. However, due to the realities of constant violence and political tensions, even MSF cannot reach all those who need care in order to see real improvements in reproductive health indicators at the population level. Their services must be complemented with on the ground community centered efforts directed at prevention. In addition, Improvements in advocacy and funding both within the organization, as well as throughout the global community must be implemented in order for further advances to be seen in the field of reproductive health, especially during CHE.

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